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<b>State:</b>	Arkansas	<b>Filing Company:</b>	American Family Life Assurance Company of Columbus
<b>TOI/Sub-TOI:</b>	H21 Health - Other/H21.000 Health - Other		
<b>Product Name:</b>	A90063R13		
<b>Project Name/Number:</b>	AuthorizationsR13/		

## Filing at a Glance

Company:	American Family Life Assurance Company of Columbus
Product Name:	A90063R13
State:	Arkansas
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Form
Date Submitted:	08/23/2012
SERFF Tr Num:	AFLA-128656136
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	A90063R13
Implementation	On Approval
Date Requested:	
Author(s):	Connie Gates
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	09/07/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas

Filing Company: American Family Life Assurance Company of Columbus

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: A90063R13

Project Name/Number: AuthorizationsR13/

## General Information

Project Name: AuthorizationsR13

Project Number:

Requested Filing Mode: Review &amp; Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Deemer Date:

Submitted By: Connie Gates

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments: Nebraska approved similiar versions of the forms on August 23, 2012.

Market Type: Individual

Individual Market Type: Individual

Filing Status Changed: 09/07/2012

State Status Changed: 09/07/2012

Created By: Connie Gates

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

filing description letter is attached under Supporting Documentation

## Company and Contact

### Filing Contact Information

Connie Gates, Policy Analyst

1932 Wynnnton Road

Columbus, GA 31999

cgates@aflac.com

706-596-5048 [Phone]

706-660-7080 [FAX]

### Filing Company Information

American Family Life Assurance

Company of Columbus

1932 Wynnnton Road

Columbus, GA 31999

(706) 323-3431 ext. [Phone]

CoCode: 60380

Group Code: 370

Group Name:

FEIN Number: 58-0663085

State of Domicile: Nebraska

Company Type: Life and Health

State ID Number:

## Filing Fees

Fee Required? Yes

Fee Amount: \$100.00

Retaliatory? No

Fee Explanation: \$50 per form  
2 forms = \$100

Per Company: No

Company	Amount	Date Processed	Transaction #
American Family Life Assurance Company of Columbus	\$100.00	08/23/2012	61943985

<b>SERFF Tracking #:</b>	AFLA-128656136	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	A90063R13
<b>State:</b>	Arkansas	<b>Filing Company:</b>	American Family Life Assurance Company of Columbus		
<b>TOI/Sub-TOI:</b>	H21 Health - Other/H21.000 Health - Other				
<b>Product Name:</b>	A90063R13				
<b>Project Name/Number:</b>	AuthorizationsR13/				

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/07/2012	09/07/2012

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Flesch Certification	Connie Gates	08/24/2012	08/24/2012

<b>State:</b>	Arkansas	<b>Filing Company:</b>	American Family Life Assurance Company of Columbus
<b>TOI/Sub-TOI:</b>	H21 Health - Other/H21.000 Health - Other		
<b>Product Name:</b>	A90063R13		
<b>Project Name/Number:</b>	AuthorizationsR13/		

## Disposition

Disposition Date: 09/07/2012  
 Implementation Date:  
 Status: Approved-Closed  
 HHS Status: HHS Approved  
 State Review: Reviewed-No Actuary  
 Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Flesch Certification	Approved-Closed	Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Authorization to Obtain Information	Approved-Closed	Yes
Form	Authorization to Disclose Information	Approved-Closed	Yes

<b>SERFF Tracking #:</b>	AFLA-128656136	<b>State Tracking #:</b>		<b>Company Tracking #:</b>	A90063R13
<b>State:</b>	Arkansas	<b>Filing Company:</b>	American Family Life Assurance Company of Columbus		
<b>TOI/Sub-TOI:</b>	H21 Health - Other/H21.000 Health - Other				
<b>Product Name:</b>	A90063R13				
<b>Project Name/Number:</b>	AuthorizationsR13/				

## Amendment Letter

Submitted Date: 08/24/2012

Comments:

The filing description letter was updated with the previous SERFF tracking and Approval Date.

Changed Items:

### Supporting Document Schedule Item Changes:

Satisfied -Name: Flesch Certification

Comment: A filing desription with Flesch Certification signed by a company officer is attached below.

DTG ltrSERFF.pdf

State: Arkansas

Filing Company: American Family Life Assurance Company of  
Columbus

TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other

Product Name: A90063R13

Project Name/Number: AuthorizationsR13/

## Post Submission Update Request Processed On 09/07/2012

Status: Allowed  
Created By: Connie Gates  
Processed By: Rosalind Minor  
Comments:

### General Information:

Field Name	Requested Change	Prior Value
Status of Filing in Domicile	Authorized	Pending
Domicile Status Comments	Nebraska approved similiar versions of the forms on August 23, 2012.	

<b>State:</b>	Arkansas	<b>Filing Company:</b>	American Family Life Assurance Company of Columbus
<b>TOI/Sub-TOI:</b>	H21 Health - Other/H21.000 Health - Other		
<b>Product Name:</b>	A90063R13		
<b>Project Name/Number:</b>	AuthorizationsR13/		

## Form Schedule

Lead Form Number: A90063R13							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/07/2012	A90063R13	OTH	Authorization to Obtain Information	Initial:	57.890	A90063R13.pdf
2	Approved-Closed 09/07/2012	A90078R13	OTH	Authorization to Disclose Information	Initial:	57.140	A90078R13.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

## AUTHORIZATION TO OBTAIN INFORMATION

**MAIL TO:** American Family Life Assurance Company of Columbus  
[1932 Wynnton Road  
Columbus, Georgia 31999-0001]

I authorize American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac") to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau).

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): any medical professional, medical care institution, pharmacy-related service organizations, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc. (formerly known as the Medical Information Bureau), consumer reporting agency, or employer.

"Information" includes facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, Policy Service, [1932 Wynnton Road, Columbus, Georgia 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date this authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

---

Printed Name of Individual Subject to Disclosure

---

Signature

---

Date

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

---

Printed Name of Legal/Personal Representative

---

Legal Relationship

(e.g. Power of Attorney, Estate Executor)



## AUTHORIZATION TO DISCLOSE INFORMATION

**MAIL TO:** American Family Life Assurance Company of Columbus  
[1932 Wynnton Road  
Columbus, Georgia 31999-0001]

I authorize American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac") to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau).

I understand that this information will be used by MIB, Inc. for the purpose of assisting the insurance industry in the accurate underwriting of insurance products as well as assisting the insurance industry in facilitating the fair pricing of insurance products through more accurate risk assessment.

"Information" includes information in Aflac's possession relating to my physical or mental health or condition (excluding psychotherapy notes, but including, for example, medical diagnosis/treatment information related to underwriting), and nonmedical financial information (including, for example, policy status).

I understand that any disclosure of health information to MIB, Inc. means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that Aflac has taken action in reliance on this authorization. My revocation must be submitted in writing to Aflac, Policy Service, [1932 Wynnton Road, Columbus, Georgia 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date this authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

---

Printed Name of Individual Subject to Disclosure

---

Signature

---

Date

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

---

Printed Name of Legal/Personal Representative

---

Legal Relationship  
(e.g. Power of Attorney, Estate Executor)

<b>State:</b>	Arkansas	<b>Filing Company:</b>	American Family Life Assurance Company of Columbus
<b>TOI/Sub-TOI:</b>	H21 Health - Other/H21.000 Health - Other		
<b>Product Name:</b>	A90063R13		
<b>Project Name/Number:</b>	AuthorizationsR13/		

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/07/2012
Comments:	A filing desription with Flesch Certification signed by a company officer is attached below.		
Attachment(s):			
DTG ltrSERFF.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/07/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	09/07/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/07/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	09/07/2012
Bypass Reason:	N/A		
Comments:			



Deborah T. Grantham  
AIRC, HIA, ACS  
Second Vice President  
Compliance Department

August 23, 2012

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201-1904

NAIC # 60380

**RE: Authorization to Obtain Information Form A90063R13 and Authorization to Disclose Information Form A90078R13.**

Dear Commissioner:

The above referenced forms are being submitted for your review and approval. Previous versions of these forms were approved on July 3, 2012 under SERFF tracking AFLA-128535377. Once approved, Aflac will begin using the revised forms no later than January 1, 2013.

Effective January 1, 2013, MIB will require all MIB members to include language in their MIB Authorizations that elicits an applicant's express written consent to report information to MIB. The language has been incorporated into the first paragraph of the previously approved forms A90063R and A90078R.

We have also changed "policy effective date" to "date this authorization is signed" in the following paragraph of both forms:

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date this authorization is signed.

The previously approved form numbers, A90063R and A90078R have been changed to A90063R13 and A90078R13 in order to reflect these changes.

***I certify that the forms submitted herewith comply with the:***

- applicable provision of Rule and Regulation 19 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of Arkansas Insurance Department;*
- requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.*

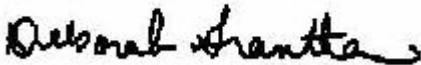
I certify that this submission meets the *Arkansas Statute Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act*. The scores for each form are as follows:

	<b><u>FLESCH</u></b> <b><u>Score</u></b>	<b><u>Grade</u></b> <b><u>Level</u></b>
Authorization to Obtain Information A90063R13	57.89	7.13

Aflac reserves the right to alter the format of the forms without refiling due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval. We also reserve the right to use these forms in an electronic format, but Aflac certifies we will retain the filed final print format. We have included brackets in the forms around the company address in the event it changes in the future.

This filing has been prepared by Connie Gates. Should you have any questions or comments concerning this submission, please do not hesitate to call her collect at (706) 596-5048, by fax at (706) 660-7080 or email at [cgates@aflac.com](mailto:cgates@aflac.com).

Sincerely,



Deborah T. Grantham  
DTG/CG/cg  
Enclosures

<b>State:</b>	Arkansas	<b>Filing Company:</b>	American Family Life Assurance Company of Columbus
<b>TOI/Sub-TOI:</b>	H21 Health - Other/H21.000 Health - Other		
<b>Product Name:</b>	A90063R13		
<b>Project Name/Number:</b>	AuthorizationsR13/		

## Superceded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/23/2012	Supporting Document	Flesch Certification	08/24/2012	DTG ltrSERFF.pdf (Superceded)



Deborah T. Grantham  
AIRC, HIA, ACS  
Second Vice President  
Compliance Department

August 23, 2012

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, AR 72201-1904

NAIC # 60380

**RE: Authorization to Obtain Information Form A90063R13 and Authorization to Disclose Information Form A90078R13.**

Dear Commissioner:

The above referenced forms are being submitted for your review and approval. Previous versions of these forms were approved on xx/xx/2012. Once approved, Aflac will begin using the revised forms no later than 01/01/2013.

Effective 1/01/2013, MIB will require all MIB members to include language in their MIB Authorizations that elicits an applicant's express written consent to report information to MIB. The language has been incorporated into the first paragraph of the previously approved forms A90063R and A90078R.

We have also changed "policy effective date" to "date this authorization is signed" in the following paragraph of both forms:

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date this authorization is signed.

The previously approved form numbers, A90063R and A90078R have been changed to A90063R13 and A90078R13 in order to reflect these changes.

***I certify that the forms submitted herewith comply with the:***

- applicable provision of Rule and Regulation 19 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of Arkansas Insurance Department;*
- requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.*

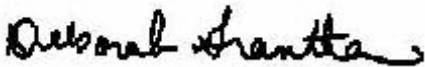
I certify that this submission meets the *Arkansas Statue Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.* The scores for each form are as follows:

	<b><u>FLESCH</u></b> <b><u>Score</u></b>	<b><u>Grade</u></b> <b><u>Level</u></b>
Authorization to Obtain Information A90063R13	57.89	7.13
Authorization to Disclose Information A90078R13	57.14	7.15

Aflac reserves the right to alter the format of the forms without refiling due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval. We also reserve the right to use these forms in an electronic format, but Aflac certifies we will retain the filed final print format. We have included brackets in the forms around the company address in the event it changes in the future.

This filing has been prepared by Connie Gates. Should you have any questions or comments concerning this submission, please do not hesitate to call her collect at (706) 596-5048, by fax at (706) 660-7080 or email at [cgates@aflac.com](mailto:cgates@aflac.com).

Sincerely,

A handwritten signature in black ink, appearing to read "Deborah T. Grantham". The signature is fluid and cursive, with a long, sweeping underline.

Deborah T. Grantham  
DTG/CG/cg  
Enclosures